



## **SAFETY PROGRAM:**

Oct 2010

### **REPORTING AN INJURY/ILLNESS OF A CONTRACTED EMPLOYEE HIRED THROUGH MARATHON STAFFING, INC.**

The injured/ill employee is to report such at the time of occurrence to his/her Production Team Leader / Supervisor who will:

1. Notify Don Buckner of Marathon Staffing, Inc., by telephone, WP (803) 753-1772 or Cell (803) 760-3784, of the incident
2. Notify BCB Safety by telephone of the incident:
  - a. Holly Bockow, WP 737-2311 / Cell 513-5354
  - b. Bernie Lee, WP 737-2315 / Cell 513-5352
3. Have the injured/ill employee, witnesses and supervision complete the following accident forms and send via electronic scan or fax to:
  - a. Don Buckner of Marathon Staffing, Inc., at:
    - i. E-mail: [dbuckner@marathonstaffing.com](mailto:dbuckner@marathonstaffing.com)
    - ii. Fax: (803) 760-3784
    - iii. Address: 1314 Lincoln Street, Suite 306, Columbia, SC 29201
  - b. BCB Safety at:
    - i. E-mail: [HBockow@oed.sc.gov](mailto:HBockow@oed.sc.gov) and [BLee@oed.sc.gov](mailto:BLee@oed.sc.gov)
    - ii. Fax: 737-3065

If the injury/illness is not serious (does not need an ambulance for transport to the emergency room), Marathon Staffing will coordinate care for the injured/ill employee and direct where to go for that care.

Holly Bockow, BCB Safety, will follow-up with the injured/ill employee's supervisor and the employee until his/her return to full duty.

The following documents and included procedures are required by Marathon Staffing, Inc. for accident reporting.

The Language Used In This Document Does Not Create An Employment Contract Between The Employee And The Agency. This Document Does Not Create Any Contractual Rights Or Entitlements. The Agency Reserves The Right To Revise The Content Of This Document, In Whole Or In Part. No Promises Or Assurances, Whether Written Or Oral, Which Are Contrary To Or Inconsistent With The Terms Of This Paragraph Create Any Contract Of Employment.

## Employee Statement

**Employee Name** \_\_\_\_\_

**Date of Incident/Injury** \_\_\_\_\_

1. How did the incident occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. When did the incident occur? Day/Date \_\_\_\_\_ Time \_\_\_\_\_ a.m. or p.m.
3. Where exactly did the incident happen (i.e. machine #, dept.) ? \_\_\_\_\_
4. What were you working on when the incident happened (i.e. product/product #) \_\_\_\_\_
5. What part of the body was injured (be specific i.e. left or right side of body part)? \_\_\_\_\_
6. What specific activity were you engaged in when incident occurred? \_\_\_\_\_
7. Were you using a tool or piece of machinery when injured:  
  
Please describe \_\_\_\_\_  
\_\_\_\_\_
8. Were there any Witnesses to your incident? Yes or No If yes, please list the names \_\_\_\_\_

### Comments

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To the best of my knowledge the above questions are answered truthfully, Sworn to me this \_\_\_\_ day  
of \_\_\_\_\_ 20\_\_\_\_.

I understand that I will need to submit to a drug/alcohol test according to the company drug/alcohol policy.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

# EMPLOYEE STATEMENT

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**Employee Name:**

**Date & Time Incident Occurred:**

(use another sheet if needed)

**Employee Print Name:**

**Employee Signature**

**Date:**

**Work Related Incident/Injury Investigation**  
**Witness, Manager, Staff Person and Group Leader Statement**

**Employee Name** \_\_\_\_\_ **Date of Incident/Injury** \_\_\_\_\_

**Name of Person Completing Statement** \_\_\_\_\_ **Position** \_\_\_\_\_

1. Were you in the area where the incident happened? \_\_\_\_\_
2. Where exactly did the incident happen? \_\_\_\_\_
3. Did you see the incident happen? \_\_\_\_\_
4. What exactly did happen? \_\_\_\_\_  
\_\_\_\_\_
5. Was it obvious that the employee was hurt? \_\_\_\_\_
6. What part of the body was injured (be specific i.e. left or right side of body part)? \_\_\_\_\_
7. Was the employee using a tool or piece of machinery when injured?  
Please describe \_\_\_\_\_  
\_\_\_\_\_
8. Have you ever heard the employee complain of similar injury or illness? \_\_\_\_\_
9. Have you ever heard the employee talk about on-the-job injury before? \_\_\_\_\_
10. Are you aware of any other incidents, personal or on-the-job, that this employee has had?  
If so, describe \_\_\_\_\_  
\_\_\_\_\_
11. Did the employee violate a known safety rule? \_\_\_\_\_
12. Did you know for a fact that employee was aware of safety rule? \_\_\_\_\_
13. Do you know if employee was ever cautioned by manager or anyone else about unsafe work habits? \_\_\_\_\_
14. What do you think caused the incident? \_\_\_\_\_
15. What can be done to prevent a similar incident in the future?  
\_\_\_\_\_  
\_\_\_\_\_

**Comments**

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(Please use the second page for additional space)

To the best of my knowledge the above questions are answered truthfully, Sworn to me this \_\_\_\_ day  
of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

# WITNESS STATEMENT

Page 2

Witness Name:

Employee Name:

Date & Time Incident Occurred:

(use another sheet if needed)

Witness Print Name:

Witness Signature

Date:

## Refusal for Medical Treatment

I, \_\_\_\_\_ was orally offered medical treatment  
by \_\_\_\_\_, but have chosen not to be treated  
at this time.

I understand that I must submit to a drug/alcohol test, complying with company policy. A fax or photostatic copy of this statement shall be considered as effective and valid as the original.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date